PASSPORT to Health Summit
Helena
April 26, 2005

Examine the four objectives of the PASSPORT Program

1. Reduce and control health care costs

a. How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?

- SSI and Managed Care are a good team.
- Limiting patient to one PCP versus letting the patient go anywhere they want.
- Study for referrals for surgery are saving money.
- Folks on Program have someone to help sort what to do.

b. What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?

- We don't have much data to answer this question: Costs to the Medicaid program in comparison to other health care delivery systems.
- Two-sided: We deal with schools. The client is not educated about PASSPORT. (The Department provides education to clients through several different means including but not limited to phone calls, welcome letters, reminder letters, assignment letter, client handbooks, brochures, newsletters, and the Medicaid helpline.) Providers refuse to give us numbers.
- A foster mom with three kids didn't even know what PASSPORT is.
- Even when a visit is appropriate, referrals aren't available. They don't always know.
- Small clinic and the expense of the machine.
- When you assign a patient with a provider they aren't aware of, the clinic is confused; they've never seen the patient before and won't give us a referral.
- Patients are assigned to a provider who they aren't familiar with.
- You may not have achieved a medical home nor establishment of a relationship with PCCM. It's an issue of congruity B medical home and Nurse First.
- PASSPORT Program is incongruous with hospital program and its payment system. Consumers don't consume care in only emergency rooms. Physicians are in both places. It makes no sense.
- With pregnancy, there aren't enough PASSPORT providers. They won't take new clients. Preventive care isn't happening, which contributes to higher costs.
- On the 1500 requiring 4 in box 24, with a pregnancy, you have to resubmit all your claims. It makes us handle a claim two times.

c. What do you suggest for the future? What other arrangements could better meet this objective?

- Make them see their PCP before they see a specialist. No appointments UNTIL you see a PCP. We can't get hold of their PCP.
- Relationship between PCP and client: improve it.
- Move toward prior authorization and away from referrals.
- PASSPORT can only change at the beginning of the month. Could there be a time limit when you move and the PCP be allowed to be changed at other times than the beginning of the month. The patients don't notify the docs. Records.

- PASSPORT providers are only chosen by the people and never assigned. (The Department does assign clients to providers if the client fails to choose their own PASSPORT provider after 3 phone calls and 3 reminder letters being sent to him/her.)
- Better client relations with their PASSPORT provider.
- Midwifery saves substantial money, a 1/4 to 1/3 savings.

2. Foster a medical home between provider and clients

a. How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?

- When they actually use their primary provider.
- One sends a welcome letter.
- See our list of who has requested us.
- Medical home is successful and contributes to preventive care.
- Accountability to the patient: They can't just go to another provider if they don't like the first one.

b. What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?

- Patients don't read the letters they receive, and don't know they've been re-assigned.
- No pediatricians in the community and patients can't travel out of town. Why assign them to a pediatrician when they will stay in town and see a local doctor?
- 17% of the PCPs didn't refer them on. How do we administer this better so it doesn't happen?
- Patients are confused about who their PCP is.
- We tie the patients' hands; they can't change providers on a whim. (Clients not on Team Care are allowed to change their provider once each month.)

c. What do you suggest for the future? What other arrangements could better meet this objective?

- Help clients read what we send them; improve communications with them.
- Let the patient choose the doctor. (We give the client at least 6 opportunities to choose his/her own provider.)
- Welcome examinations for Medicaid so the PCP can see that person and know where to get his or her records.
- Give patients the opportunity to change providers at any time, with a no bouncing rule of X times per year.
- Re-examine hat is considered the Medical Home. No longer a silo, make it integrated, especially in rural communities.
- In helping clients read the information, have a mandatory education day. The more he/she knows, the less mistakes will be made, versus handing them the information packet to go home and read.

3. Assure adequate access to primary care

a. How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?

- The $3 fee contractually binds us to care for the patient. It makes the assignment binding, not to pay for the time you spend.
- From the emergency room , pre-authorization has gone away B a major improvement in our lives!
- Having clinic PASSPORT and not just provider PASSPORT.
- The letters aren't hard to read.

b. What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?

- Some providers don't look at the fee as a binding contract. They refuse to honor the fact that they are a provider and don't give the patient a proper referral.
- Barriers to care, especially for those least able to navigate the system. Discharge planning: some people haven't had primary care in a long time. We start with the Social Security system, paperwork, appointments when they leave the hospital and receive case management. Coordination of Social Security, many lists of what to do while they are worrying about their next meal. The person is overwhelmed, doesn't read the information and needs help navigating the system and understanding the notices.
- The increasing tendency for doctors to drop out of the program or limit slots, which equals a further burden on those who haven't dropped out.
- No shows for appointments. Sometimes patients are high maintenance. They need a lot more management than the current system can provide.
- We need to attract more adult providers.

c. What do you suggest for the future? What other arrangements could better meet this objective?

- Consider a requirement for providers to see patients within certain time requirements, within a certain number of days for emergent, urgent, routine sick and routine well care.
- Only the patient or legal guardian can change the provider. Is there a way providers can call and ask for a change, such as when they refuse. Guardians, kids, 30+mile distances all are barriers. (Providers are allowed to disenroll a client as long as the reason for disenrolling is not to avoid high cost medical care. The exception to this would be if the client's behavior interfered with the providers ability to provide treatment to others. In that case, the Department must be notified.)
- No shows with a certain number of no shows are allowed to be kicked out. (A provider can disenroll a client for multiple no shows..see response above.)
- Divide out the SSI patients and pregnant women.
- Recruit more providers.

4. Encourage preventive care

a. How is PASSPORT successful in meeting this objective? What do you appreciate about it? What currently works smoothly?
- Expedited appointment screening.
- Being able to do vaccines for children in our offices.
- You pay for preventive care and not just sick care!

b. What doesn't work as well as you need or want it to? What problems do you experience? What concerns do you have about this objective?
- Patients don't get to get care, and don't come in until they are sick.
- Grade school children and teenagers are not coming in nor are aware of regular visits.
- It's a difficult population.

c. What do you suggest for the future? What other arrangements could better meet this objective?
- Patients go for their care.
- Send copies of the notices the providers get to the families; remind both of us.
- Figure out better ways to educate this population about preventive care. Tell them why to do it and its value, and use many approaches to educate them.
- Require regular wellness visits to maintain their Medicaid eligibility.
- Health care accounts: Allocate money into accounts for this for each person. Have a use it or lose it policy.
- Are all the appointments considered the same? Can there be a financial incentive for the patient to encourage they stick to a schedule of well visits?

If primary care case management is the best option, what aspects of the current program could be improved?

- For complex patients, include a case management fee. Pay more for those patients on the monthly statement. Provide more incentive to see them.
- Give the provider a little more control over his/her caseload, versus the patient stipulating or being assigned.
- Allow the PP to be changed at any time.
- Limit the amount of paperwork to that which gathers data, and improves the Program or the patients' care.
- More sympathetic providers' office staff for when specialists call for an okay.
- The identification card burden is on the doctor's offices, which incurs a lot more expense we aren't reimbursed for. It works, but at a cost to us.
- Shifts in cost to doctor's offices have taken place, and this needs to be reimbursed.
- CM, not the providers, take a more active role and coordinate with more ancillary services.

- Assign a coordinating case manager.
- Not all offices have a little machine. When there are changes in MEPS, if we could be informed, it would be helpful. Now you have to stumble upon the changes.
- Regarding MEPS, so many times it's not accurate. We're told if you want what's correct, you have to go through the phone system, which is tedious. Make MEPS more up-to-date.
- Have Medicaid buy everyone a machine, including the school districts.
- Emergency rooms evaluate patients for acute care. Allow anyone to evaluate for acute care. Let them do their own mini-screen. You could send them a reminder about their normal medical home. It would extend their medical home to the whole community.
- Education of clients regarding what to expect and sign up B mandatory education.
- Provide adequate reimbursement for providers B reimbursement for services B so the providers can afford to give the services.
- Incentivize the patients and providers. Do some pilot projects across the state and compare what works best.

Referral system:

a. If a referral system is the most effective way to meet our objectives, how should the Department ensure that a PASSPORT referral number is secure (used only by the provider for the services for which it was given)?

- After the fact, send a report to the offices so we can nip it in the bud. We won't know unless we get a report from Medicaid.
- Purple cards used in South Dakota picked up at provider to take to the specialist.
- Ease up on when a referral is needed. Allow post-operative follow-up, as an example.
- Specialists are referring on and deciding to admit them versus the provider doing it.
- An electronic referral, versus the MEPS system.
- We don't need a PASSPORT number if the provider ordered the service. Flag it by who ordered it. Services are ordered without a number. The provider shouldn't need a number to order a service, resulting in less of the number being out there. We should use the referring physician on the form.
- If fraud is taking place, pursue it.
- Spot check for who you talked to, and when and how they got the number. Especially if someone is using our numbers.
- One in six patients who see specialists didn't get referred. Was this two specialists or 200? It amounts to a lot of dollars.
- What is the penalty? A spectrum of responses result: warning, refunds and rarely prosecution. A lot of specialists wouldn't care to lose Medicaid patients. Fear of prosecution will drive specialists away from participating.
- Uniform referral sheet we could all use for patients that still want to see a doctor, but don't yet have a referral. With a clause disclaiming: We didn't get a number, you will pay for this visit yourself.

b. Are there services which should require a referral?

- Orthopedic visit for a broken arm, in a school situation.
- All diagnosis that would require a specialist.
- Any time you are billing out an evaluation and management code. (Not everyone agreed with this, especially emergency room representatives.)
- Hospital: Orthopedic doctors admits, and wants a surgeon to look at the patient. Piggybacking is not okay as an outpatient, but to delay a consult six hours while we look for the number could create a dangerous delay in patient care. This just changed; change it back. Pay for PCPs to be involved in inpatient stays that require specialists. Give PCPs without hospital privileges a method to do referral inside hospitals. Keep the PCP involved.
- Collaborate with nursing homes who are not currently part of PASSPORT regarding discharge planning.

c. Conversely, are there services which should not require a referral?

- Specialist / orthopedic, possibly a broken arm, from a school nurse.
- Medical care provider to another medical care provider.
- What any reasonable person considers an emergency, and that's all.
- School district: IEP requirements such as speech therapy. Doctors refuse because they don't feel they have the expertise or it's not in their realm. Help educate the providers. Send them copies of the IEPs.
- Currently aren't required for pharmacies (but do require prior authorizations), lab work, and ....
- The system should have controls over drugs., CTs, and MRIs. You should have some controls here too, but it will be a hard pill to swallow, and will need a lot of physician input to create.

Create your own model B small work groups' proposals

Model A

- Reduce health care costs: Medicaid health care team B internal medicine, family practice, ME.
  - New graduates B student loan compensation.
  - Teaching facility.
  - Nurse First beefed up (on-site nurses).
- Foster a medical home.
  - Client / physician selection: provider directory with pictures, biographies, a personal touch, based on MCH healthcare team.
  - Electronic healthcare record within infrastructure.
- Assure adequate access to primary care.
  - Team travels weekly.
  - Nurse First.
  - Develop a healthcare team.

- Mobile clinic associate with MCD healthcare team.

Model B

- Increase cooperation between the three areas B client, provider and program staff.
- Greater focus on education of the client B in person, regularly scheduled, less reliance on written materials. Greater involvement of the case worker in education and support.
- Possible role of providers' office staff as a liaison for the client.
- Medicaid system to pay providers at a better level so they can provide the necessary services and support. Recognize the burden placed on the provider's office regarding checking eligibility, billing (difficult for small provider offices).
- Possibility of having a primary care provider as well as a secondary care provider, especially in rural areas and remote areas.
- Need for more on-site training of providers and office staff in the rules of the program.
- Standardized referral forms to improve communication between providers and security of process.
- Look at ways to improve communications BACK from specialists to PCP so PCP stays informed. Avoid duplications.
- Concept of "welcome visits" with the new provider, establishing a medical record so the provider can provide appropriate referrals. Welcome visit could include preventive care (exams, shots, and education.)
- Educate clients about making appointments and keeping appointments. If no-show, client could be asked to pay costs. Role of case worker in educating clients about problems with no-shows. Availability of transportation options. General courtesy to providers; need to call if can't make appointment.
- Look at after-hour options for providers so that clients could have more access options, such as access to transportation.
- Increase reimbursement for house calls. Encourage greater access to services.
- For "high risk" clients, providers should be able to and encouraged to get the picture of the "whole client" B life circumstances, home, not just clinic presentation.

Model C

- **Promote medical home.**
    - Allow patient to change PCP with more flexibility, but refer bouncing ones to management.
    - Intro PCP visit reimburse with new clients / new PCP.
- PCP
    - Referrals.
    - Communication electronic. Can referrals send not back to PCP even if referred wasn't required?
    - Case management of complex patients (SSI, bouncy patients, frequent ER visits). Team care and Nurse First.
    - Compensation is key:
        - Service reimbursement should be equal to or greater the actual cost of the visit.

Our estimates: $35 for level 2, $60 for level 3, $100 for level 4, and $150 for level 5.
    - Reimbursed more for proven better care, minus compliance., such as immunization rate. Quality Pacific B DM, asthma. Health screening rates. Visits, year, dy compliance.
- Data on referrals sent to PCP from Medicaid billing information and ER visits and formulary compliance.

Model D

- Education! Education! Education! for recipients.
- Education! Education! Education! for providers / specialists.
- Medical home: recipient should be allowed to PICK provider.
- Sweeten the pot for PASSPORT providers.
- Have more requirements for sweetened pot, more patients per provider.
- SSI patients B case management fee would be higher for needy patients.
- Consequences for Medicaid recipients that will not comply??
- Establishing care within one month, for PCP.
- Try a test run of notification, of preventive services.
- If recipient doesn't comply, provider should be able to bill them.

Model E

- Foster incentives to increase oversight of inpatient and pharmacy to encourage clients to utilize less and providers to order less.
- Preventive care: Pay client to meet and complete an established care program.
- Physician panel to determine what services should be prior authorized.
- Incentives for physicians group / hospital groups to develop pilot projects. Share savings with Medicaid. Probably area specific.
- Incentives to clients who first contact primary care prior to going out to another provider. Educate clients; simplify. Payment to see new PASSPORT doctor in first month.
- Supply physician with information on what services each client is due for.
- Incentive for providers that ensure the client completes the preventive regime.
- Open access pilot project with incentives for providers who keep appointment slots open for immediate care.

Model F

- Promote preventive healthcare. Increase education efforts to both client and provider communities. Notify PCP of client well care needs (chronic).
- Create a case management system to foster medical home relationships.
- Increase financial incentive. Create a system of recognition.
- Create a higher reimbursement scale for preventive care.
- Preventive care advertisement campaign.

The future and your priorities

a. What do you want the PASSPORT Program to avoid doing in the future.

- Avoid alienating PASSPORT patients from not understanding the Program and avoiding medical care. Important because the patient care is most important no matter who is paying the bill.
- Avoid policies that work against other program goals. Make PASSPORT policy compliment hospital and physician payment policies and goals. Make the Program make sense to all stakeholders.
- Alienating providers so they won't participate in Medicaid programs.
- Perpetuating the status quo.
- Assisting patients B self determination.

b. What do you want them to do less of in the future?

- Quit coddling the clients. Expect responsibility for their own health care, or will forfeit their benefits. They must be a part of the team. (Someone added "I agree.")
- Deny fewer claims.
- Changing PASSPORT numbers. It's important because patient could be seen during old number and PCP gives new number and physicians RAs from old provider numbers never reach the $5 limit.
- Patient PCP assignment.
- Less paperwork, more electronic.
- Make clients more responsible for their own care, possibly giving them get written referrals.
- Denying claims for minor infractions.

c. What new approaches do you recommend?

- Better education to clients and providers.
- If clients know and follow rules, less denials for specialists or urgent care.
- Mandatory education day. Important because providers and clients need to better understand the PASSPORT system.
- Recognize Medicaid clients are more like the general population. Allow care at urgent / convenient care etc. without penalties.
- Give list of PCPs to patient to choose from. (The Department sends a list to each PASSPORT household of providers practicing in their county.)
- Data to doctors, such as report card.
- Use regional case managers for providers, patients and department staff to facilitate communication.
- Offset to education loans for serving PASSPORT patients. Promotes access. Maybe salaried positions.
- Provide public recognition for providers who offer medical services for Medicaid. Offset for low reimbursement.
- More education for everyone concerned so that all know what to expect from the programs

such as preventive health.

- Solicit focused pilot projects to address over-utilization in various localities.
- More case management. If PCP is to do it, pay them for complex case management, such as $100/month.

d. What minor adjustments do you recommend the Department and Program consider carefully?

- Provide utilization data back to providers.
- Provider who used our PASSPORT number in the last month. Important because we could detect fraud. (Someone added "ditto.")
- Implement a case management program at the state level.
- Either get rid of ER diagnosis / procedure code list or commit to continued modification.
- Ease up on needing referrals for acute care.
- Provide machines for PCP verification and cover expenses of the prior authorizations and of actual visit costs and all other added components.

e. What major overhauls do you recommend the Department and Program consider?

- Increase reimbursement. Why: costs are going up, not down.
- Figure out a way to reimburse both.
- Pay for performance.
- Hold patients accountable for seeing their PASSPORT doctor and for making co-pays. Important to keep costs down for everyone.
- Provide incentives to patients for preventive care and compliance. Saves money in the long haul.
- Provide incentives to PCP for providing services to patients. Large draw on funds. Provider needs extra compensation to stay in the Program.
- Allow PCP changes immediately.
- Implement changes to insure that the Medicaid system is more in line with Medicare instead of being two or more years behind.

Individual Worksheets Helena PASSPORT Summit April 26, 2005

1. What do you most want the Program to consider from today's conversations?

Hospital or providers at a hospital:

- Nurse triage phone number; great idea. Better education of your clients; have health education days.
- Better reimbursement. Case management.
- Use of a nurse / social worker as a local (regional) case manager to help both patients and providers work within the system. Community health centers have case managers and so do hospitals and insurance companies to manage care.
- More information to cover CAH claims, such as clinic claims.
- Better education for everyone. A prime example is the Medicaid manual. It needs updating with more current information, possibly on line like Medicare's with update notification.

PCP:

- Improved communication between PASSPORT and provider: what care is needed and medication profile. More incentives for patients and providers.

Billing office staff or office managers:

- Create more education (structured).
- Education of clients B mandating sit down when accepted to Medicaid. Better reimbursement for physicians.
- Education.
- Get the clients better educated to the PASSPORT Program.

Others:

- Consider reducing the burden on the providers while increasing the education and program changes that incent the client.
- Exempt speech therapy services conducted in the school districts from PP approval.
- EDUCATE: clients and providers of the PASSPORT Program (use, moving from county to county refusal to disclose number for services). ELECTRONIC referral number of acceptance.
- Incentives for docs and patients. Pilot projects with potential gainsharing with DPHHS.

2. What do you find the most frustrating about the current approaches?

Hospital or providers at a hospital:

- Reimbursement.
- PCP referrals used to CONTROL patients even if visit would've been appropriate. IF ER DOESN'T NEED referral when appropriate, WHY DOES ANYONE ELSE seeing acute care? Patients need educated and then allowed to make their own choices (more autonomy, let them grow responsible), then if they prove unable to make good choices, put them in a case management structure.

- Lack of knowledge from providers and clients. More education is needed more often.
- Medicaid not recognizing physician charges on UB92 form, when Medicare requires us to file as one claim. Medicaid denies those line items. We elected the Method 2 through Medicare for filing claims.
- Medicaid reimbursement for Swing Bed patients is at best a joke and for the most part is a slap in the face. Most of the patients who fall into this category have catastrophic illnesses without prior need for medical care. In other words, they weren't with a PCP before admission, and at admission one is assigned.

Billing office staff or office managers:
- Passport patients to wrong PCP.
- Lack of accountability for MCD clients.
- Clients stating I don't know.
- PASSPORT provider numbers changing.

Others:
- Programs tend to pursue own goals at the expense of other programs. Too "silo" oriented.
    - 1. Physician can refuse to give the school district permission to bill for services conducted by a licensed professional according to the IEP, simply for the fact that the parent has not changed the PP.
    - 2. Lack of communication (effective) and coordination of services between clients, provider and department.
- Extra work for providers; more denials when claims are submitted.
- Little innovation. Major dilemma for us; money pressure not to participate, but this is totally against our mission.

3. What would make you a champion and supporter of PASSPORT, and truly advocate for it?

Hospital or providers at a hospital:
- I am the medical home. I don't want to be the parent (no door keeper, just care). Incentives for preventive maintenance taker will help patients make the right choices! I support medical home and PLP when hospitalized and for preventive medicine B prior authorizations for non-acute care (such as surgery) and referrals ONLY FOR NON-urgent specialist care are good. Good communication back to PCP is important. Use a nurse triage for acute care rather than PASSPORT referral because nurse is not trying to control who the patient accesses. Only appropriate access will be denied.
- Allow for some "grey" areas in lieu of rigid rules because we are dealing with humans who don't always fit into neat categories.

PCP:
- Data supporting improved health care as a result of PASSPORT system. Improve reimbursement.

Billing office staff or office managers:

- Better reimbursements for preventive care.
- If clients understood it and were required to comply.
- If the clients would be responsible enough to know that they have to see their PP before they see a specialist.

Others:

- PASSPORT working to educate and guarantee access for client without punishing those who actually deliver the care.
- 1. More control by the providers to dictate whether or not a person stays on their "list." 2. More flexibility to change PP-client or provider in times they can be changed. 3. Better communication between providers, clients and the department.
- When the system providers good service to clients, good support and respect from provider, and still says it can save money, then I will truly be an advocate and supporter for PASSPORT.
- Work with DPHHS as genuine partner to improve the system. We want to be part of the solution, not the problem.

PASSPORT to Health Summit in Helena **April 26, 2005**

Meeting evaluations summary

1. **What were the most productive or helpful or interesting segments of today's meeting**?

- The discussions, suggestions and comments were very beneficial. Writing the suggestions down was also good.
- The presentation was workable. Writing down comments and suggestions was a great idea. Also having audience participation was more productive.
- All the different ideas of how to improve the program.
- Section 3 and 4 (examining the four objectives of the PASSPORT Program and if primary care case management is the best option, what aspects of the current program could be improved); could be a little shorter.
- All the participants gave ideas. I loved hearing the other providers' problems. We are not alone!
- Brainstorming for ideal models.
- I got a lot of diverse comments from the whole healthcare system with doctors, providers, billings staffs for hospitals and clinics, and staff from the various agencies involved with PASSPORT.
- My ability to participate and hear other opinions.
- Be allowed to say anything and MCD staff being courteous and not defending themselves. It was also very interesting to have staff at table with us during "create your own model" and hearing their ideas.
- Knowing the four objectives of PASSPORT.
- Creating new models.
- Getting the opinions and feedback from so many different entities that fed into the PASSPORT Program.
- Good group discussion. Good facilitator.
- Input from all areas of Montana. Listening to their concerns and successes. Facilitator did a good job of keeping group focused.
- Hearing the clinic and school-based provider perspective.

2. **What were the least productive or helpful or interesting segments of the today's meeting?**

- Groups.
- Each of us are still "relaxed" into our own areas and not looking at overview of the PP Program.
- A little too much repetition in some of the tasks.
- Repetitive brainstorming B was good to an extent.
- The referral discussion.
- Receiving two copies of the articles. Having people answer each other, although Beki worked very hard (and did a great job of controlling meeting).
- More facts regarding cost savings studies. Inappropriate use of provider numbers and

patient demographics would've allowed us to be more fact based in suggestions. (Yes we had lots of questions, and those in the know were discouraged from responding, but we need all the facts. The more I know, the better my input can be! It's my though process! I guess I could've done more study before the meeting.)

- None identified, and breaks were timed just right too. Disruptions were minimized and thus conducive for productivity.
- Nothing.
- None.
- Not being able to hear all the comments and questions.
- Some of the comments were difficult to hear.

3. **Did you accomplish what you wanted to accomplish? If so, what subjects or issues or topics were they? What, if anything, did you get out of the meeting**?

- Yes, we were able to ask questions on issues we were having problems with and get answers on direction for.
- Issue: What types of forms for Medicare/Medicaid claims to use when claim has both TC and PCs.
- Yes. Ideas for developing and meaningful pilot project at DPHHS.
- Venting.
- Yes, I learned a lot about the PASSPORT Program; its strengths, its weaknesses.
- The questions, concerns and comments for my particular field have been addressed, namely the need for education of clients AND providers to make the Program workable.
- We'll see!
- It was great to see positive enforced along with the comments and suggestions.
- Yes, controlling medical cost.
- Yes.
- Yes! Greatest concern for the school districts is resistance by the Providers in cooperating with our IEP Mandated Services. We are not the only one facing these obstacles.
- Informative.
- Yes.

4. a. **What changes and improvements do you suggest for future meetings like this one**?

- Try to get more physician involvement. Maybe send them open-ended questionnaire. Continual education at all levels.
- Utilize better communication s between case workers and clients and then better communication between providers sharing their PASSPORT provider number.
- Ice breakers so people feel free earlier to talk.
- Referrals B standard form.
- Shorter time.
- Possible eliminate #8 (walk around brainstorm).
- I hate group sessions and reporting.

- More time for general conversation with Medicaid staff.
- None.
- Put tables in a round setting so you can hear everyone.
- Have seating in horse shoe / circle formation to be able to hear what's going on. Gear topics pertinent to CAH.
- Provide more data regarding cost and utilization issues that are problems for DPHHS.
- #8, not sure new ideas were presented.
- Have meeting in Butte.

4. **What would you like to have left exactly as it was at this meeting? Keep these characteristics**:
   - Interaction and brainstorming sessions helpful.
   - Well facilitated.
   - Use of physical documentation of comments and suggestions.
   - Keep paper record of the comments, suggestions, etc.
   - Agenda.
   - Organized format good. Keep on agenda and on time!
   - Very well organized. Moved along at a great clip!
   - Open forum for ideas. Neutral facilitator.
   - Referrals for all E/M visits so primary PCP is aware of all happenings.
   - Size was great.
   - Having one primary care provider.

5. **Any other feedback, suggestions or ideas**?
   - Continued dialogue with providers, consumers, and department personnel to help prevent big problems (such as provider rebellion by refusal to participate in Medicaid program).
   - This meeting was very well organized. Kept on track and informative. Thank you for your hard work and efforts.
   - Shift burden off of providers.
   - More education for providers and clients, forcing a loop with the Department.
   - Thank you for asking for our input!
   - Consider having a session in Great Falls.
   - I think ALL PCP providers should be required to attend these meetings.